California MEDICAL ASSOCIATION

NOTICES & REPORTS

Health Care for the Aged

SUMMARY OF TESTIMONY BY THE CALIFORNIA MEDICAL ASSOCIATION

- Many progressive steps for the aged have already been taken in California, including accreditation of nursing homes and related facilities and opportunities for upgrading of personnel training in these facilities.
- A California study on aged welfare patients shows that more than six out of seven sought assistance for other than medical care needs.
- Last census showed that 29 per cent of the families over 65 in California had the head of the family in the work force. In addition, in 17 per cent of the families, other members were in the labor force.
- Old Age Assistance (OAA) and Medical Assistance for the Aged (MAA) programs in California cover over 275,000 aged persons.
- An estimated 560,000 in the state have some form of voluntary health insurance coverage.
- The MAA program in the state has emphasized long-term chronic care in hospitals and nursing homes. It has not been satisfactorily implemented, but modifications have been recommended.
- The California Medical Association suggests to the committee that study be given to the adequacy of OAA allowances which may have some bearing on the implementation of MAA programs throughout the country.
- The burden of proof for a radical change in present methods of providing care is on the proponents of H.R. 3920.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for allowing me the opportunity to present the views of the California Medical Association on the provision and financing of health care of our aged population.

My name is Samuel R. Sherman. I am a Doctor of Medicine. Since 1933 my medical practice in San Francisco has been devoted to general surgery. Currently I serve as President of the California Medical Association which comprises approximately 22,000 practicing Doctors of Medicine in one of the largest states in the country. For ten years I have been a member or chairman of the governing council of this state organization. The information I bring to this committee, then, represents what I believe to be the viewpoint of the vast majority of our physician membership.

For decades our state medical association has been concerned with a host of problems and activities involving the health of the people of California. Today, roughly 450 practicing physicians serve without remuneration on 75 active commissions and committees of our association. These study and recommendatory bodies deal with nearly every conceivable health problem including mental health, disaster medical care, occupational health, traffic safety, medical aspects of sports, continuing medical education, maternal and child care, scientific information, school health, rural health, dangerous drugs, and many others, including the socio-economic aspects of medical care for various segments of our population.

C.M.A. Activities for the Aged

Regarding the aged population in California, we have endeavored to take the broadest possible approach to their health care needs.

Out of this concern and attention was organized,

A statement before the Committee on Ways and Means, United States House of Representatives, by Samuel R. Sherman, M.D., President of the California Medical Association.

in December of 1959, the California Joint Council to Improve the Health Care of the Aged. This Council represents the inter-disciplinary cooperation of the five sponsoring organizations, including the two dental associations in our state, California Hospital Association, California Association of Nursing Homes, and the California Medical Association. The objectives of the Joint Council include: (a) Identifying and analyzing the health needs of the aged, (b) Appraising available health resources for the aged, (c) Fostering effective methods of payment for the health care of the aged, (d) Developing community programs to foster the best possible health care of the aged, (e) Promoting health education programs for the aged, and (f) Informing the public of the facts related to health care of the aged.

In pursuit of these objectives the Joint Council, with active support of the medical association, has initiated two specific efforts which I would like to call to the attention of this committee:

One is the formation of the California Commission for the Accreditation of Nursing Homes and Related Facilities. This is a voluntary, non-profit group supported by the same member organizations. Recognizing the importance of adequate nursing homes in the provision of health care of the aged, the Commission developed standards for measuring health care in nursing homes and related facilities which exceed, in quality, the minimum requirements for licensure. We continue to support this effort to improve the quality of health care provided to the aged in nursing homes in our state.

The second is the organization of the California Coordinating Committee for the Education of Personnel in Facilities for the Aged. Again, formation of this committee has had the full support of our association. The membership of this committee includes representatives from several state voluntary associations, state governmental departments of social welfare, mental hygiene, public health and education, private colleges, and the state college system. Purposes of this committee include upgrading educational standards and providing opportunities in adult education for personnel working in facilities for the aged. We are particularly pleased to note the excellent cooperation existing among the several nongovernmental and state governmental agencies which participate in this committee.

Aged Population in California

If I may now, I would like to turn our attention to a discussion of several facts regarding the aged population in California.

Census data of 1960 reveal that there were 1,376,200 persons over 65 years of age living in California. Of this number 822,967, or 59.8 per cent were receiving OASDI benefits; 255,973, or 18.6 per cent were receiving Old Age Assistance; and 122,482, or 8.9 per cent were receiving both OASDI and OAA.

The notion has been fostered by some that all or many of the hardships of the aged are caused by medical needs. Our State Department of Social Welfare conducted a study from July 1960 to June 1961 of the reasons for granting aid to Old Age Assistance recipients coming on the rolls in California during that period. The sample studied included 27,501 persons. As might be expected, significant reduction in income caused 57.3 per cent of them to seek welfare assistance. However, only 8.3 per cent of this group was found to have had their assets reduced or exhausted by medical care costs. The remaining 42.7 per cent of those who qualified for the program had suffered no recent significant reduction in income or resources. The recent medical care needs of only 7.5 per cent caused them to seek assistance. Thus, for the total sample, approximately 15.8 per cent might be said to have sought assistance because of the need for help in meeting medical care costs. More than six out of seven sought assistance for *other than medical care needs.*

We conclude from this study that the cost of medical care constitutes only a small percentage of the causes of economic hardships encountered by the aged. Yet, it is the hardship of medical care expense which is continually cited as the major reason for providing hospitalization through taxation for nearly all those 65 or over as suggested in H.R. 3920. The need for supplemental income when one loses his steady income or other means of support is a much greater hardship for many people over 65 than is the cost of medical care.

Regarding the income status of the over-65 population in California, the last census showed that in 29 per cent of the families over 65 in our state, the head of the family was in the labor force. In addition, in 17 per cent of the families, other members were in the labor force. The median annual income of these families was $3,681. A substantial number of people over 65 are still in the labor force in California, and apparently are as able to take care of their medical needs as when they were under 65.

The favored income tax provisions for the aged and their smaller budgeting needs (including clothing, housing, education of children, job transportation, etc.) indicate that they require less dollar income in comparison to families of younger age.

Voluntary Health Insurance in California

The progress which has been made in the provision of voluntary health insurance programs to persons over 65 in California is striking evidence of the manner in which the aged medical care prob-

lem is being attacked by the professions, insurance industry, management, labor and the aged themselves.

A report of the national Health Insurance Institute indicates that, as of October 1962, 55 per cent of the total noninstitutionalized aged population in the United States was enrolled in some form of voluntary health insurance.

If we apply this 55 per cent to California, subtracting the approximately 275,000 aged whose health care is provided through Old Age Assistance and MAA and the 70,000 institutionalized population in our state, then we have over 560,000 aged persons in California with some form of voluntary health insurance coverage.

To understand better the number and types of voluntary health insurance plans available to aged persons in California, the Bureau of Research and Planning of the California Medical Association was commissioned to survey the companies offering over-65 coverage in our state. Their report, issued in November 1962, revealed that at least 70 companies and prepayment plans were then offering approximately 140 different voluntary health insurance programs to the aged in our state. Other companies are planning to add new or expanded programs. (Incidentally, the Bureau of Research and Planning of our state association has been responsible for contributing to our knowledge on several important socio-economic subjects, including programs for the aged. One of these is a Data Sourcebook on the Aged, several copies of which I have filed with your committee counsel.)

At this time older persons in California can obtain health care benefits under many different forms of voluntary health insurance. The various types of coverage offer a wide scope of benefits through a wide range of premium costs. These programs, which are available to older persons on an individual or group enrollment basis, provide guaranteed renewable coverage during the life of the individual. The survey did not include the variety of programs and policies offered by many insurance and prepayment organizations and other health insurance mechanisms which enable the individual to convert his policy and become eligible for benefits upon retirement. We earnestly hope that no action will be taken to retard the growth and development of these voluntary health insurance programs in our state by removing the incentive for them.

An additional development in California, as far as voluntary health insurance is concerned, is the passage of permissive legislation by the 1963 General Session of the California Legislature which permits insurance carriers to pool their resources to provide improved programs of coverage to persons 65 and older. We are encouraged with this progressive step to protect further our senior citizens.

Sixty insurance companies have joined in this cooperative effort and they will offer—under the title of Western 65—three plans for the senior citizens of California. This insurance will be available March 1, 1964.

Prepayment Experiment in Santa Barbara County

It is our hope that all Public Assistance Medical Care and Medical Assistance to the Aged programs will be financed eventually through the insurance principle.

As an experiment in this regard, our California Blue Shield Plan (California Physicians' Service) is now serving as the prepayment vehicle in PAMC and MAA programs in Santa Barbara County. This project has been in effect since February, 1963, and has the full support of physicians in the area.

We hope that the favorable experiences resulting from this prepayment experiment can be adapted throughout California.

Kerr-Mills Implementation in California

The 1961 General Session of the California Legislature partially implemented the Kerr-Mills Law by enacting the California Rattigan-Burton Law. This 1961 law provided payments for long-term chronic care in hospitals and nursing homes and other benefits. However, the rules of eligibility permitted OAA recipients to be transferred to MAA when they were in need of long-term care in a hospital or nursing home. The Law became effective January 1, 1962.

During the first full year of operation (1962), the MAA program in California covered 27,539 persons with inpatient benefits. The total amount of monies spent during this period was 46 million dollars or an average of $1,670 per beneficiary.

After one year of experience we recommended that certain changes be made to improve this health care program by providing for acute care in hospitals.

The principal 1963 modification finally adopted now allows for payment for the first 30 days' care—acute care— if confinement occurs in a county or contract hospital. Thus, choice of hospital is still unnecessarily limited.

Let me make it perfectly clear, for the benefit of the committee, that the California Medical Association believes the mechanism of MAA under the Kerr-Mills Law at the national level is adequate and desirable. We think that this law, with its emphasis on helping those persons who need it and giving them all the help required, is the best solution to the problem for this segment of the population.

It is unfortunate that many states, including California, have failed to provide the new funds needed

to implement the law. Some state administrations are urging the Congress to increase Social Security taxes under H.R. 3920, an increase in California taxes alone of over $200 million, but they refuse to ask their own legislatures to appropriate a much smaller amount to match MAA funds.

It is difficult for us to understand how our own Governor can advocate passage of H.R. 3920 thus burdening his constituency with increased Social Security taxes, instead of promoting the full implementation of an already existing program (MAA) which can do an effective job.

Certain provisions of the Federal law have allowed the transfer of OAS patients to MAA without spreading benefits to new patients in significant numbers. We think one possible cause of this procedure on the part of state and county governments is that present Federal funds for OAA are inadequate to cover hospital and nursing home care. There is a ceiling on OAA matching funds, but none on MAA. We respectfully urge the committee to consider seriously the matter of improving the existing OAA medical care allowances which would, in effect, stop the shifting of OAA cases to MAA.

As far as MAA in California is concerned, we will continue to use our best efforts to improve the program and make it fulfill the original intent of the Congress. We have confidence that our Legislature, working in cooperation with our association and several other governmental and nongovernmental agencies, will respond in the future to whatever changes in the MAA program seem indicated—changes which will benefit the aged in California.

Adequate Programs Already Exist

My testimony would not be complete if I failed to comment on the effective manner in which other facilities of our State make their services available to citizens. The system of county hospitals in California, county health department clinics, local mental health facilities—all are, and have been, available to the aged. I am proud to say that many members of our association contribute their time and services to assure the success of these efforts.

While we recognize that there will be no single program or answer to provision and financing of health care for our aged population, we firmly believe that the plurality of existing efforts is sufficient to accomplish the task. Taking into consideration the economic status of our aged in California, we feel strongly that with our system of county hospitals, Old Age Assistance, Medical Assistance to the Aged, and voluntary health insurance, we have the mechanisms available to offer to any aged person the assurance that his health care needs will be met.

The burden of proof, we feel, is on those who would change radically our method of provision of health care for persons over 65. Legislation, such as the Social Security tax approach in H.R. 3920 and similar Federally-controlled programs would mean needless duplication and stifle the progressive steps we have already taken in California.

It would be a severe change to make the Federal government directly responsible for the payment of the health care needs of all persons, 65 and over. The inevitable Federal regulations which the administrator would have to impose, in order to carry out his fiscal responsibility, will not promote high quality medical care at the local level. In other programs, such regulations have caused unnecessary frustration and interference.

My simple plea on behalf of my professional colleagues in California is that no Federal legislation be enacted which would have the effect of retarding the positive and progressive steps being taken in California and elsewhere to improve the health care of the aged.

And now, Mr. Chairman, I believe I can most profitably use the remaining time allotted to me to review briefly the facts which have been disclosed during these hearings on H.R. 3920—material which constitutes a compelling array of reasons why this measure should be rejected.

Now, in the closing moments of these hearings, I speak not only for the California Medical Association, but for all of American medicine.

More than two months have elapsed since these hearings were recessed. Understandably, facts laid before you last November have begun to retreat into the past. Permit me to recall the more significant facts which stand in answer to the emotional appeals and generalizations employed here by the supporters of the King-Anderson bill. Permit me also to rebut certain charges which have been made by witnesses who have sought your support for H.R. 3920.

Kerr-Mills—Failure or Success?

The Kerr-Mills Law, for example, has been referred to over and over again in the testimony. You have heard its rate of progress questioned, its implementation described as spotty and slow.

On the very first day of the hearings, the Secretary of Health, Education, and Welfare, Mr. Anthony Celebrezze, stated flatly: "MAA does not help at all many of the aged who need help; and for many of those who do get some help, the help is very limited."

If true, Mr. Chairman, this is a serious charge. But I submit the record of these hearings does not bear out the allegation.

The American Medical Association offered in its testimony an exhaustive survey of the development of health care aid for the needy and near-needy aged under Kerr-Mills. This marked the first time the committee has received a comprehensive report on

the effectiveness of the law in filling the purpose for which it was designed by Congress—assisting those who can meet the expense of everyday living but who might have difficulty in meeting the expenses of prolonged illness.

The AMA report showed that under Kerr-Mills, new medical assistance programs for the aged had been established in 29 states, Guam, Puerto Rico, the Virgin Islands, and the District of Columbia. The report further stated that within a few more months, such programs will also be in operation in 36 states and the four other jurisdictions, to assist those who may need help.

As recently as last Monday, Congressman Curtis of Missouri noted that the rate of implementation of Kerr-Mills has been almost twice as fast as it was for the vendor medical payment program under the Old Age Assistance law.

On the question of how many are actually being helped through Kerr-Mills, you will recall that the testimony on the first day of the hearings disclosed that some 451,000 over-65 Americans received MAA benefits during the 1963 fiscal year.

The testimony on money expended to provide the necessary help was equally impressive. During the fiscal year ended June 30, 1963, $410.7 million in OAA funds and $287.3 million in MAA funds—well over half a billion dollars—were spent in vendor payments for health care.

Does this sound as though not many of the aged are being helped, as stated by Mr. Celebrezze? No. It reflects a record of acceptance and achievement which simply cannot be denied.

Attempting further to discredit the effectiveness of the Medical Assistance for the Aged programs, witnesses have reached for examples to present to the committee which were aimed, hopefully, at demonstrating restrictive eligibility requirements and inadequate provisions for care.

But what does the record actually show?

It shows constant improvement and strengthening of MAA. Since their original enactment of these programs, 15 states have liberalized eligibility requirements and four other states are considering such action. Benefits have been increased in 16 states, and some states have improved their programs more than once.

Spokesmen for the medical societies of Arkansas, Kentucky, Illinois, Michigan, and Pennsylvania—to touch on only a few states of varying sizes and characteristics—have told you of increased hospital benefits, of higher incomes allowed single persons and married couples, and of other advancements in their Kerr-Mills programs since the enabling legislation was passed.

You have heard Mr. Arlin M. Adams, Secretary of Public Welfare for the Commonwealth of Pennsylvania, support medicine's testimony on this point with the following words:

> Pennsylvania's partnership with the Federal Government under Kerr-Mills has made it possible to provide hospital and certain other health care to older persons who are least equipped financially to pay. Our aged population is becoming increasingly aware of the objectives of the MAA program, and are learning to use it. . . . We do not intend to rest on what has been accomplished. Our goal is to continue improving the Pennsylvania Kerr-Mills effort.

Unfortunately, as you know, this positive and encouraging approach to Kerr-Mills is not shared by all who have been trusted with its administration in the federal government. Look to the record which has been made before this committee during these hearings. How often has it been evident that those of us who seek to give the law a fair chance to prove or disprove its value, have been thwarted.

On the opening day of these hearings, the government witnesses were questioned about their lobbying and pamphleteering in behalf of King-Anderson and their obstruction of Kerr-Mills.

The next day, the distinguished Senator from South Dakota, Senator Karl Mundt, appeared before you and documented his charges that HEW officials and other King-Anderson supporters have carried out "a planned program of interference" with Kerr-Mills development. This was his testimony:

> These people, many in places of immense power, have used every means at their disposal to discredit Kerr-Mills in the eyes of the public, to confuse state legislatures in their attempts to enact proper programs, and to demean potential recipients of MAA benefits with meaningless red tape used under guise of the means test.

Then he asked, "How could any program work perfectly with this kind of hamstringing at every turn?"

It is a good question. The answer must be that it is a far better program than it has been given credit for, and, afforded an honest chance, it will do the job for which it was intended.

Insurance—A Worthy Program?

Mr. Chairman, another method of financing health care for the aged is voluntary health insurance and prepayment plans. These hearings have produced extensive, documented testimony by the insurance industry, the AMA and others on the continued dramatic growth of these mechanisms. Mr. H. Lewis Rietz, Executive Vice President of the Great Southern Life Insurance Company of Houston, Texas, who appeared in behalf of associations representing 90 per cent of the voluntary health insurance under-

written by insurance companies, testified that 60 per cent of the aged, or more than 10 million Americans, now have such protection.

Lest there be some question regarding the accuracy of this statement, let me quote it from his testimony. Under the heading, "The Current and Potential Role of Private Health Insurance," Mr. Rietz said:

> In July 1961 we estimated that 53 per cent of the non-institutionalized aged population were covered by some form of voluntary health insurance. Continuing dynamic growth has resulted in a significantly increased proportion of the aged having coverage today. By December 1962, 60 per cent of the aged had voluntary insurance.

(I have made a point of quoting from the record because on this past Tuesday Mr. Sidney Zagri, in behalf of the Teamsters Union, charged the American Medical Association with being inaccurate in its use of the 60 per cent figure as an estimate of the aged who had some form of health insurance coverage. I fear that Mr. Zagri, unaware of the authoritative source of the statistic, was a bit too anxious to represent it as a figment of AMA imagination.)

What is more, Mr. Rietz said the number buying health insurance is increasing every day. With new plans and ideas developing at a fast pace, he was able to forecast that within the next three years 70 to 75 per cent of the people over 65 would be covered by voluntary plans.

Nevertheless, the record before you shows that supporters of H.R. 3920, including such witnesses as Mr. Celebrezze and Mr. George Meany of the AFL-CIO, regard private insurance as inadequate and too expensive for aged citizens. Mr. Chairman, our private enterprise system just doesn't work that way. Overpriced products or those which fail to fulfill the claims made for them do not survive on the open market; certainly, they do not enjoy steadily increasing popularity among consumers. And we know that Americans over 65 are buying health insurance at a faster rate than any other age group.

Cost of King-Anderson—Understated

Another point on which the hearings must turn is the cost of this proposed new federal welfare program—the cost to the government, the cost to the individual working man. Surely, the testimony leaves no doubt that H.R. 3920 would be unpredictably but staggeringly expensive.

You will recall the testimony of the Department of HEW's own actuary—testimony which has been referred to many times during the course of these hearings. He admitted under examination by the Chairman that the increase in the payroll tax rate proposed in the bill should be twice as high at the start to keep the program solvent; in other words a boost of 1 per cent on a base of $5,200 rather than the one-half of 1 per cent which the proponents have claimed would be sufficient to finance hospitalization and related benefits for the entire aged population.

What does this mean to the worker? It means a steady whittling away at the take-home pay of wage earners at the low end of the income scale, many of whom do not earn enough to pay a federal income tax. Those earning $5,200 or more would, if this bill were enacted now, begin paying a total Social Security tax of $201.50, and the employer would pay a like amount. Included in the total tax of $403 would be $55 to pay for federal health benefits for millions of Americans who neither want nor need government assistance. And these figures do not include the increase Mr. Myers admitted was necessary!

This evidence also confirms the long-standing position of the American Medical Association, the insurance industry, and the many others who have analyzed the cost factors, that the government estimates have been unrealistically low—a fact which was disclosed when the HEW actuary admitted from the witness stand that he and his colleagues have in the past underestimated the cost of this kind of legislation by as much as 100 per cent.

The Aged—Are They All in Financial Distress?

From the beginning, Mr. Chairman, the question of financial need has lain at the heart of this controversy. The preamble of the measure before you portrays elderly Americans as a class of impoverished, helpless, sick human beings simply because they have passed a 65th birthday. Government witnesses and other proponents of the bill have followed this line of argument to support their claim of the overwhelming need for this legislation.

Again, what does the record show?

The testimony of the AMA and its constituent state societies has demonstrated that the medical cost problems that do exist among the aged are problems of the individual and not of an entire age group. Most of the aged are self-reliant, independent, and in control of their economic destinies. Even the President's Council on Aging was able to delineate a remarkable record of economic improvement for these Americans.

It is not possible for me at this time to review or even attempt to summarize the many and sometimes confusing array of statistics which has been presented to this committee on the health and financial condition of our aging citizens. I ask, however, that during this committee's deliberations, it once again examine the representations made by the American Medical Association whose testimony is documented in detail. It is based on facts and figures—material from HEW statistics, from Census reports, and from numerous studies and surveys made by unimpeach-

able sources. The sources are cited and the facts are fairly presented.

Permit me to refresh your recollection as to what was said by one witness. In Tuesday's afternoon hours, your committee heard Mrs. Constance Ann Field of Pittsburgh, Pennsylvania. She reviewed some of the same statistics you have heard time and time again, but did so in capsule form. Here is what she said in describing the aged individual:

> Seventy per cent of him owns his own home; 53 per cent of him already has his own insurance; the big majority of him has benefits: OASI, Railroad Retirement, civil service pensions; military pensions; private annuities; etc. As a group he has the lowest indebtedness in the United States and an average capital evaluation of $10,000.

Invitation to Overuse

Mr. Chairman, the lengthy record of these hearings contains many other significant arguments against H.R. 3920, including the profound changes in our system of health care, and the decline in its unequaled quality, which passage of this legislation would bring about. I cannot touch on them all, but I am going to take a moment to mention one point which perhaps has not been emphasized as much as it should have been in view of its fundamental importance in the consideration of this proposal. That is, the overuse of the nation's health care resources which the bill invites.

In some parts of the country, particularly in urban areas, our hospitals and nursing homes are having difficulty in meeting current demands for services. The population is growing and the economy is rising. More people are capable of buying more frequent and more extensive care. There are bound to be increasing calls for services of all kinds.

Add to these factors a program of "free" government benefits for a large segment of the population and the peril of over-crowding of the existing facilities becomes acute. Under this pressure, the quality of care in institutions strained to the limit of their resources would suffer.

The program, however well intentioned, must be viewed as an incentive for patients to use as many of the tax-financed benefits as possible. In fact, it must be assumed that many citizens would be convinced they had a vested interest in obtaining as much care as possible at government expense.

The medical profession and other providers of health care in this country long ago recognized the need for expanding facilities to keep pace with the needs of our burgeoning population as those needs could be anticipated under normal circumstances. They are doing so, and have been for some time.

The AMA and its constituent state societies have supported the Hill-Burton Act for hospital and nursing home construction, FHA mortgage insurance for proprietary nursing homes, construction of new medical schools and enlargement of existing ones. There are now 11 new medical schools in the planning state.

The AMA has also established a multimillion dollar loan guarantee program, underwritten by voluntary contributions of the nation's physicians, to encourage and assist young people to take up the study of medicine. In this connection, I am pleased to point out that the Association's Council on Medical Education and Hospitals recently reported a 10 per cent increase in the number of medical school applicants for 1962-63, the first upturn in six years.

In short, Mr. Chairman, medicine and others engaged in health care have done and are doing everything humanly possible to assure care for the sick in the years ahead. But orderly progress could be placed in jeopardy if this measure becomes law. And not only would the burden on hospitals and nursing homes approach impossible proportions, but the aged who have been led to expect so much from this bill would find themselves cruelly disappointed at being denied the promised services because there simply were not enough facilities to take care of them. I urge you to consider this point as you proceed with your deliberations on H.R. 3920.

In Conclusion

Mr. Chairman and members of the committee, this concludes our case. We in medicine who have opposed the King-Anderson plan have done our utmost to present to this committee the facts and the philosophy which underlie our position. We have appreciated your patience and the time granted to us, and we in turn hope that our testimony will assist you in reaching your conclusions.

American medicine wishes, as I am sure you do, that the subject of financing health care for our senior citizens could be aired in every forum of the land with the care and attention it has received here. We hope that the record of these proceedings will be studied by the many organizations and individuals who have an interest and concern, both for the elderly and for the welfare of our country.

We believe that when Americans in every corner of the land have the facts and understand the true issues here, there will be no question of their verdict on the King-Anderson bill. We are confident that the great majority of them will join in asking that you reject H.R. 3920 because it is unnecessary, inequitable, and an unmistakable peril to our present system of health care.

Mr. Chairman, thank you again for the courtesy which you have extended to me, to the California Medical Association and to American medicine.